P.O. BOX 4346 • MISSOULA MT 59806
406-721-2222 • 877-424-3570

www.allegianceflexadvantage.com

DEBIT CARD ENROLLMENT FORM

Personal Information

Employer _____

Name _____ SSN _____

Address _____ City _____State _____ Zip _____

Birth Date _____ ☐Male ☐Female ☐ Married ☐ Single

Email Address►

Cardholder Use Acknowledgement

1. I may only use the card to pay for eligible medical expenses.
2. I may not use the card for expenses already reimbursed.
3. I may not seek reimbursement under any other health plan for expenses paid with the card.
4. I will acquire and provide documentation for expenses paid with the card.
5. I have been provided an explanation of the fees associated with the debit card.

Employee Signature: _____ Date: _____

As a security measure your card will be mailed in a plain white envelope. Please be careful not to throw it away with the junk mail!